Practice Management Structures:
CEO and Physician Perspectives

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- BSM has been conducting studies specific to the business and operations of urology hospitals and groups for the past five years.
- BSM has conducted on-site field visits, phone surveys, and one-on-one interviews with urology groups to identify areas of opportunity and best practices around operations, management structures, and consolidation strategies.

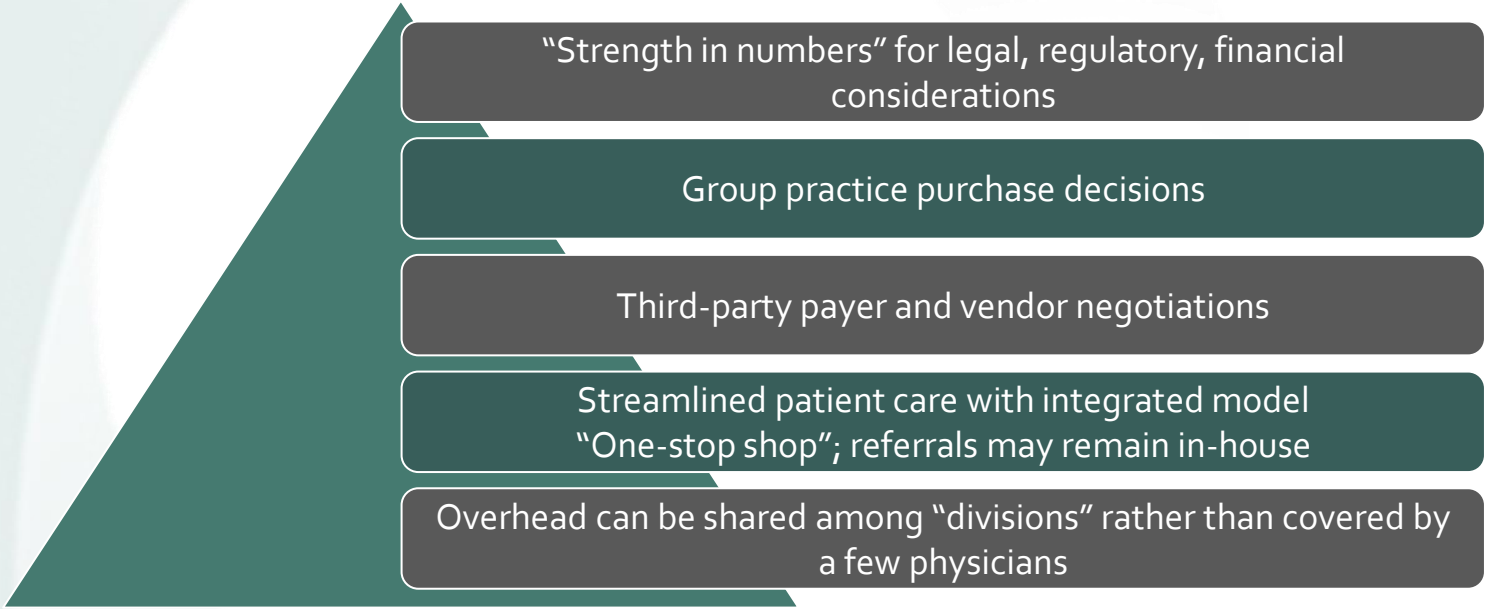
Management Structures Secret Sauce

No matter what the practice model, these are the qualities that exist in "best practice" management models:

- Strong synergies/communication between the physician lead and operations lead
- Culture conducive to alignment and collaboration
- A good balance between four elements: clinical, financial, operational, and vocational
- A sense of responsibility, accountability, transparency, and outcomes toward the management of the group

History and Evolution of the Large Urology Group Practice

Benefits of Consolidation



Drawbacks of Consolidation

- Compensation, culture clashes, and c-suite creation
- Clinical integration may be difficult
- Belief systems of physicians and administrators are inconsistent across divisions
- Many health systems and physician groups lack the ability to "move fast" with the upcoming changes in healthcare
- Human resource and personnel issues

Creating Optimal Group Governance

Successful Group vs. Successful Physicians

There's a world of difference between a **successful medical group** and a **group of successful physicians**

- Collaboration
- Bound by common vision, mission, and purpose
- Accountability to the group
- Integration and/or interdependence

VS.

- Collegiality
- Bound by professional background
- You do what you want and I do what I want
- Autonomy and independence

Emerging Business Models in Healthcare:

Emerging business models demand a higher degree of physician alignment:

- Volume to value pay structure, outcomes, protocols
- Doctors will be required to work more closely and collaboratively than ever before
- There will have to be stronger emphasis on coordination of care across the continuum
- Continuous pressure on utilization and price
- Improved IT connectivity between doctors, patients, hospitals
- Increasing prevalence of population health management and risk-based contracting

Creating a Successful Coordinated System of Care

To be successful urology groups and health systems must learn to:

- Develop a plan that supports their group's strategic goals. Create rigor around integration and alignment.
- Physicians and Healthcare leaders must participate and lead planning governance processes
- Physician plan must be integrated with the organization's overall strategic plan
- Detailed strategic and financial projections must exist to ensure the availability of capital
- Service line offerings, facilities, technology, and other resources must be aligned
- Quality, efficiency, growth, access, and patient satisfaction must be benchmarked

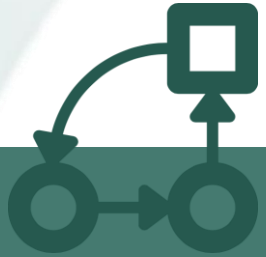
Building a Collaborative Enterprise

According to Harvard Business Review article, "Building a Collaborative Enterprise", authors Paul Adler, Charles Heckscher and Laurence Prusak list four key areas for developing a culture based on trust and teamwork:

1. A shared purpose
2. An ethic of contribution
3. The institution of independent processes
4. The creation of a collaborative infrastructure

Source:Adler, P., Heckscher C., Building a Collaborative Enterprise, 2011 http://hbr.org/2011/07/building-a-collaborative-enterprise/ar/1

Critical Factors for Optimal Performance:



One of the most important factors in developing a sustainable business model is an investment in the creation of a mutual identity with a shared mission, vision, and values.

In the case of groups contemplating a merger, these discussions should take place prior to going through the time, trouble, and expense of completing the transaction. Unfortunately, this step is frequently overlooked by group leaders as they fixate on imminent legal, financial, and operational considerations.

MD Survey: Insight into Gap Analysis of Culture/Collaboration

Partner Survey	Rating Scale				
Urology Group XYZ has developed a shared vision, mission, values that is supported by its strategy and processes.	1	2	3	4	5
Physician and Board leadership are balanced and effective.	1	2	3	4	5
A strong, respected physician leader(s) is in place to drive mission-critical decision-making.	1	2	3	4	5
Transparency and accountability exist throughout the group and is exhibited throughout day-to-day operations.	1	2	3	4	5
There is a process to achieve economic and clinical goals through collaboration and integration.	1	2	3	4	5
Financial incentives are aligned with group values and drive the right behavior for group mission, vision, values.	1	2	3	4	5
Variation in group practice patterns, quality and operational performance measures are minimal.	1	2	3	4	5

MD Survey: Insight into Gap Analysis of Culture/Collaboration

Partner Survey	Rating Scale				
Partner excellence is rewarded appropriately by group leadership.	1	2	3	4	5
Incentives are aligned appropriately for quality, patient satisfaction, and citizenship.	1	2	3	4	5
There is a process in place to address rogue or isolated partners who do not 'fit' the partner excellence structure.	1	2	3	4	5
There is a process in place to drive collaborative planning and decision making.	1	2	3	4	5
Communication across the group is fluid, honest, and open.	1	2	3	4	5
There is a culture of accountability for leadership, MDs and staff.	1	2	3	4	5

Key Success Factors

Key success factors with effective group governance include, but are not limited to:

Governing documents with clear lines of authority and decision making criteria.

Effective delegation from the Board to several functional operating committees. Each committee should have its' own charter and guiding principles.

Accountability from each operating committee to the Board for regular communications including status reports on key committee initiatives.

Board commitment to providing resources and support to develop the business skills and strengths of the leadership team.

A well-thought out succession plan focused on developing a leadership "bench" that will insure long-term stability in leadership and management of the practice.

Board commitment to a formal strategic planning process that will bring continued focus on the company's vision, mission, core values, strategies, and tactics.

Strong Leadership: A Key to Successful Healthcare Management

As mentioned, having a strong, visionary leader or leaders is one of the biggest defining factors of successful urology group practices. Effective leaders should have the following qualities:

1. Adhere to influential and authoritative, but benevolent leadership principles.
2. Motivate, inspire, and influence physicians and staff.
3. Own conflict resolution management and work effectively toward successful outcomes with administrative personnel.
4. Innovate toward strategies for creation of best practices and optimal group efforts.
5. Focus on improving health care outcomes.
6. Focus on providing opportunities for employee development while attaining financial and operational results.
7. Develop leadership opportunities for other members of the team and find creative solutions to short and long-term challenges.
8. Develop confident, principled and ethical ways to approach their job responsibilities.
9. Garner the respect of leadership, physicians, and staff.

Compensation Structures Must Be Clear and Comprehensive

The keys to success in designing a compensation structure include:

1. Align the plan with the group's vision and values.
2. Recognize individual differences in production and resource consumption.
3. Promote transparency and accountability and as such, encourage shareholders to continually strive for improvement in patient care and practice efficiency.
4. Share the risk and benefit of investments made in passive income sources such as an ambulatory surgical center and employed non-owner providers.
5. Avoid making the plan too complicated to administer or requiring continuous tweaks to satisfy individual shareholder requests.

Model #1: Productivity with Shared Resource Allocation

There are two primary compensation models most often seen in urology group practices.

The first model is one where revenue from all sources is pooled, overhead is paid "off the top" and profits are shared between the owners.

With this type of model there is some variability among groups in terms of how the net profits are shared. In most instances, some agreed upon percentage of net income is shared equally with the remainder allocated based on the individual production of the shareholders. In most instances, production is measured based on net collections (gross receipts minus patient refunds). The work component of Medicare Relative Value Units (RVUs) traditionally is used as a measure of productivity.

Group Practice Compensation Model
Income Sharing Model with Net Income Allocation 50% Equal and 50% on Production

	Doctor A	Doctor B	Doctor C	Doctor D	Doctor E	Total
Revenue						
Owner MD Collections	$752,410	$677,360	$670,190	$792,755	$599,250	$3,491,965
Associate MD Revenue						2,603,328
Other Income						85,412
Less Refunds						(67,668)
Total Revenue						**$6,113,037**
Owner Production Percentage (1)	21.55%	19.40%	19.19%	22.70%	17.16%	100.00%
Overhead Expenses						
Expenses (2)						$2,920,867
Associate MD Salary						911,165
Total Overhead Expense Allocation						**$3,832,031**
Net Income						**$2,281,006**
Income Distribution (2)						
Income Distribution - Equal (50%)	$228,101	$228,101	$228,101	$228,101	$228,101	$1,140,503
Income Distribution - Production (50%)	245,743	221,231	218,889	258,920	195,720	1,140,503
Total Income	**$473,843**	**$449,332**	**$446,990**	**$487,020**	**$423,820**	**$2,281,006**
Physician Direct Expenses						
Retirement Contribution	($45,000)	($45,000)	($45,000)	($45,000)	($45,000)	($225,000)
Health Insurance	(19,554)	(12,003)	(18,652)	(16,455)	(13,625)	(80,289)
CME	(5,850)	(4,200)	(5,050)	(6,879)	(3,850)	(25,829)
Other Direct Expenses	(2,633)	(2,510)	(2,088)	(2,965)	(2,200)	(12,396)
Total Physician Direct Expenses	**($73,037)**	**($63,713)**	**($70,790)**	**($71,299)**	**($64,675)**	**($343,514)**
Net Income Distribution	**$400,806**	**$385,619**	**$376,200**	**$415,721**	**$359,145**	**$1,937,492**

FOOTNOTES

(1) The owner production percentage has been calculated by dividing the individual owner-MD collections by the total owner-MD collections.
(2) Expenses include the cost of supplies.
(3) Income is allocated to the owner-MDs as follows: 50% allocated equally and 50% allocated based on individual production percentage.

Model #2: Productivity-Based Model

The second approach to compensation commonly found in urology group practices is a more "individualistic" approach where revenue is allocated to individual shareholders and overhead expenses are assigned based on an agreed upon formula. In these models, there are several categories of overhead expense including direct overhead, shared and non-shared expenses.

Direct expenses would include the items noted above and relate directly to the production of revenue. Shared expenses include the general and administrative expenses associated with operating the practice. Non-shared overhead items include the physician direct expenses noted above and are generally allocated by individual shareholder.

Group Practice Compensation Model
Profit Center Model with Overhead Expenses Allocated 50% Equal and 50% on Production

	Doctor A	Doctor B	Doctor C	Doctor D	Doctor E	Total
Revenue (1)						
Owner MD Collections	$752,410	$677,360	$670,190	$792,755	$599,250	$3,491,965
Associate MD Revenue	520,666	520,666	520,666	520,666	520,666	2,603,328
Other Income	17,082	17,082	17,082	17,082	17,082	85,412
Less Refunds	(13,534)	(13,534)	(13,534)	(13,534)	(13,534)	(67,668)
Total Revenue	**$1,276,624**	**$1,201,574**	**$1,194,404**	**$1,316,969**	**$1,123,464**	**$6,113,037**
Owner Production Percentage (2)	21.55%	19.40%	19.19%	22.70%	17.16%	100.00%
Cost of Goods Sold	**($65,000)**	**$0**	**$0**	**($105,000)**	**$0**	**($170,000)**
Overhead Expenses (3)						
Expenses - Equal (50%)	($366,203)	($366,203)	($366,203)	($366,203)	($366,203)	($1,831,016)
Expenses - Production (50%)	(394,527)	(355,174)	(351,415)	(415,682)	(314,217)	(1,831,016)
Total Overhead Expense Allocation	**($760,730)**	**($721,378)**	**($717,618)**	**($781,885)**	**($680,421)**	**($3,662,032)**
Total Owner Income	**$450,894**	**$480,197**	**$476,786**	**$430,084**	**$443,044**	**$2,281,005**
Physician Direct Expenses						
Retirement Contribution	($45,000)	($45,000)	($45,000)	($45,000)	($45,000)	($225,000)
Health Insurance	(19,554)	(12,003)	(18,652)	(16,455)	(13,625)	(80,289)
CME	(5,850)	(4,200)	(5,050)	(6,879)	(3,850)	(25,829)
Other Direct Expenses	(2,633)	(2,510)	(2,088)	(2,965)	(2,200)	(12,396)
Total Physician Direct Expenses	**($73,037)**	**($63,713)**	**($70,790)**	**($71,299)**	**($64,675)**	**($343,514)**
Net Income Distribution	**$377,857**	**$416,484**	**$405,996**	**$358,785**	**$378,369**	**$1,937,491**

FOOTNOTES

(1) Owner MD collections are allocated to the individual provider; all other revenue is allocated equally to the owners.

(2) The owner production percentage has been calculated by dividing the individual owner-MD collections by the total owner-MD collections.

(3) The overhead expense allocation includes associate MD salary of $911,165.

THANK YOU